EDICAL CARE STATISTICS SECTION
Department of Health Services

1998 MANAGED CARE ANNUAL STATISTICAL REPORT

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The Managed Care Annual Statistical Report provides information about the managed care programs rendering care to Medi-Cal beneficiaries. It provides a description of the types of programs providing managed care services to Medi-Cal beneficiaries, the number of persons enrolled, and a description of some of the demographic and eligibility characteristics of this population.

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ANNUAL STATISTICAL REPORT
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Introduction

The Managed Care Annual Statistical Report provides information about the medical managed care programs rendering care to Medi-Cal eligibles. It provides a description of the types of programs providing managed care services to Medi-Cal beneficiaries, the number of persons enrolled, and a description of some of the demographic and eligibility characteristics of this population.[1]

The Managed Care Annual Statistical Report does not provide cost or utilization information for the Medi-Cal managed care population. Cost data for this population as well as those in fee-for-service are available in the Annual Statistical Report issued by this Section. Managed care utilization information is currently limited but may become available at a future date from the State Department of Health Services (DHS). Detailed information about dental managed care can be obtained from the DHS Payment Systems Division, Office of Medi-Cal Dental Services.

This report is comprised of three Sections, each of which describe the managed care program and its population in the broader context of the whole medical Medi-Cal program. These Sections are: 1) history and description, including current enrollment data; 2) demographic characteristics; and, 3) eligibility continuity and rate of new eligibles.

Section 1, History and Description of Medi-Cal Managed Care

Until recently, Medi-Cal has predominately used a fee-for-service (FFS) health care delivery system to provide care to its beneficiary population. Under this system, qualified providers render care or provide drugs, durable medical equipment (DME) items, etc. to beneficiaries, then bill the State; upon adjudication of their claims for services, the providers are paid the Medi-Cal allowed amount.

Managed care is a planned, comprehensive approach to the provision of health care combining clinical services and administrative procedures within an integrated, coordinated system to provide timely access to primary care and other necessary services in a cost-effective manner. Under managed care, individual providers are linked together into a system that formalizes the often informal provider relationships that exist under fee-for-service (FFS) and brings them together under a single entity, the managed care plan. The plan manages the linkages and is accountable for performance and outcomes. Managed care's emphasis on access to primary care is intended to increase utilization of clinical preventive services and thus reduce both the unnecessary use of emergency rooms for ambulatory care and preventable hospitalizations. In turn, this enables the plan to reallocate its resources to promote preventive and primary care for its members.

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[1]The terms “eligible,” “beneficiary,” and “enrollee” are used interchangeably within Medi-Cal. Each refers to a person who meets all requirements for receiving a Medi-Cal medical service or good (e.g., drugs, DME items) and is enrolled in the Medi-Cal program. These terms are in contrast to the term “user,” who instead is an eligible/beneficiary/enrollee actually using a service or receiving a drug, DME item, etc.

Section 1.1, History of Medi-Cal Managed Care

The Medi-Cal Program began covering eligible beneficiaries in March 1966. In May 1972 Medi-Cal beneficiaries began enrolling in managed care plans when the first Prepaid Health Plan (PHP) contract went into effect. Joining a PHP was voluntary, and limited to those in a public assistance aid category. In June 1983, a new type of managed care program, the County Organized Health System (COHS), began covering Medi-Cal beneficiaries when the Monterey Health Initiative became operational. This program stressed case management and utilization control in the delivery of health services to Medi-Cal eligibles. A few months later, in September 1983, the Santa Barbara Health Initiative began operating a COHS in that county. Both were similar in that almost all beneficiaries in the county were mandated to join the plan. However, whereas the Monterey program stressed local control Primary Care Case Management, Santa Barbara stressed centralized utilization control. For various reasons, the Monterey COHS ceased operations in July 1985.

In August 1984, a third Medi-Cal managed care program began operation, the Primary Care Case Management (PCCM) program. Enrollment in PCCM plans was voluntary, like the PHP program, but excluded inpatient service coverage and certain specified outpatient services. The PCCM stressed assignment of a personal physician to each beneficiary in the plan, and that physician authorized virtually all other services delivered by the PCCM plan. In December 1987, a third COHS, the Health Plan of San Mateo, began operating.

State legislation in 1991 and 1992 enabled a substantial expansion of Medi-Cal managed care, primarily for AFDC-linked eligibles.[2] Pursuant to this legislation, the Department of Health Services (DHS) started the process of developing and implementing a Geographic Managed Care program in two counties, a Two-Plan Model program in twelve counties, and the COHS program in three additional counties. (See Appendix, Table A.1 for a list of the aid categories each of these plans cover.) In addition, a Medi-Cal Fee-for-Service Managed Care Program began in the counties of Sonoma and Placer in March and October 1997, respectively; this program involves paying the contracted local government a fee per eligible per month for 1) establishing a primary care physician network from which beneficiaries select or are assigned to a personal physician, and 2) case managing the services received by the Medi-Cal beneficiaries.

The 1991 managed care legislation was significant in that prior to 1991 in a county in which Medi-Cal managed care plan enrollment was available, beneficiaries who made no affirmative choice between FFS and a plan were "defaulted" into FFS. With the 1991 legislation, the state was allowed under specific circumstances to direct the defaults into managed care.

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[2]The term Aid to Families with Dependent Children, or AFDC, is being replaced by other terms and programs, pursuant to recent Federal and State legislation. For example, some persons formerly eligible under AFDC will become eligible under California's "CalWorks" program, which implements the Federal "Temporary Assistance to Needy Families" (TANF) program. Other formerly AFDC eligibles would be referred to as eligibles under Section 1931b of Title XIX of the Social Security Act. For ease of understanding and due to evolving eligibility definitions, this report will use the old term of AFDC.

Section 1.2, Description of Medi-Cal Managed Care

Before 1994, there were only three managed care programs providing medical care to the Medi-Cal population, the Prepaid Health Plan program, Primary Care Case Management program, and the County Organized Health System (COHS) program. From 1994 forward, two more programs were developed and implemented, the Geographic Managed Care program and the Two-Plan Model program. Then, in 1995 and 1996, three additional counties formed COHS organizations. Currently, there are five managed care programs enrolling Medi-Cal eligibles: Prepaid Health Plans (full capitation, voluntary), Primary Care Case Management plans (inpatient services excluded, voluntary), County Organized Health Systems (most aid categories, mandatory), Geographic Managed Care plans (AFDC-linked, mandatory) and Two-Plan Model plans (AFDC-linked, mandatory). The following describe each of these programs.

Prepaid Health Plan

The State Waxman-Duffy Act authorized HMO contracting in the Medi-Cal Program and referred to such plans as Prepaid Health Plans (PHPs). In California, the PHP contracting program was established as an alternative to FFS. The intent of the program was to provide the AFDC-linked Medi-Cal beneficiaries who enrolled with access to organized, mainstream systems of health care. PHPs are required to provide, on a capitated, at-risk basis, all basic Medi-Cal covered benefits, excluding specified treatments, such as major organ transplants, chronic renal dialysis and long term care. (Refer to Appendix, Table A.1 for a complete list of aid categories and their classifications.) In addition, PHPs operating under managed care principles provide case management, preventive and health maintenance services. As managed care contractors, PHPs have other requirements not found in FFS, such as quality of care, membership services, and member grievance procedures.

DHS administers the contracts with the PHP contractors. The Department of Corporations, Division of Health Care Service Plans, oversees their operations as commercial health plans under the Knox-Keene Act. Because of their status as licensed commercial health plans, and because they typically provide care to privately insured individuals as well as Medi-Cal beneficiaries, PHPs are considered mainstream health care providers and, as such, have been significant participants in DHS' efforts to expand managed care. In the Two-Plan Model counties, enrollments have been limited until full implementation of the Two-Plan Model/GMC plans, at which time PHP contracts are terminated in those counties.

Primary Care Case Management

The Primary Care Case Management (PCCM) program is a managed care model that covers outpatient, physician, and some other outpatient services. PCCMs exclude inpatient services and some outpatient services from the scope of benefits provided under their capitated services.

Under PCCM arrangements, primary care providers contract with DHS as managed care plans to

provide and assume risk for primary care and specialty physicians' services and selected outpatient preventive and treatment services; inpatient services are excluded. (Refer to Appendix, Table A.1 for a complete list of aid categories and their classifications.) PCCM contractors are required to case manage all services provided to their enrollees. Contractors participate in program savings through savings sharing agreements with DHS. Shared savings must be produced by the PCCM's effective case management of services for which the PCCM is not at risk, the most significant of which is inpatient hospital care.

PCCM contracts operate under DHS' review and oversight. Although PCCMs have not been directly subject to either the Knox-Keene or Waxman-Duffy Prepaid Health Plan Act, many of the relevant requirements are reflected in these contracts. In the Two-Plan Model counties, PCCM plan enrollments have been limited until full implementation of the Two-Plan Model plans, at which time PCCM contracts are terminated in those counties. Once all of the mandatory managed care programs are in operation, only a few PCCMs will remain in operation.

Geographic Managed Care

Sacramento County was selected for the development of a Geographic Managed Care (GMC) program in early 1992, and was started April 1994. Under Sacramento GMC, DHS contracted with seven managed care health plans for medical services and four dental care plans for dental services. The California Medical Assistance Commission negotiates capitation rates with each plan; rates are kept confidential. The mandatory aid category groups are: Aid to Families with Dependent Children (AFDC), Medically Needy with no share of cost, and Medically Indigent children. (Refer to Appendix, Table A.1 for a complete list of aid categories and their classification.) Medi-Cal beneficiaries allowed to join voluntarily include those who are in an SSI or foster child aid category or who otherwise meet certain medical exemption criteria. Beneficiaries enrolled with a commercial or Medicare HMO are not allowed to enroll. In addition, eligibles in a mandatory aid category will not be in a plan during the months they are retroactively eligible for Medi-Cal, or for the first two months of their eligibility, during which time they are going through the selection/assignment process.

DHS received waivers of federal requirements for freedom of choice that permitted provision of Medi-Cal benefits to this population exclusively through managed care plans, under GMC. State legislation in 1994 permitted a second GMC program, called "Healthy San Diego," to be formed in San Diego county. The projected start-up for the San Diego GMC program is mid-1998.

Under GMC, covered beneficiaries are informed about the available managed care plans and then are asked to select a plan to join. Beneficiaries are assisted in the selection process through the involvement of a Health Care Options (HCO) contractor who provides a presentation and explanatory materials. If a beneficiary does not select a plan to join, he/she is assigned to an available plan.

Initially, five of the seven plans were fully-capitated PHP plans, with the remaining being PCCMs. As of May 1997, there are six comprehensive PHPs that cover inpatient as well as all other medical services. DHS directly contracts with each of these GMC plans.

County Organized Health Systems

Under the County Organized Health System (COHS) model, a local agency, with representation from providers, beneficiaries, local government, and other interested parties, is created by a county board of supervisors to contract with the Medi-Cal program. Operating under federal Medicaid freedom of choice and other waivers, the COHS administers a capitated, comprehensive, case managed health care delivery system. The COHS has the responsibility for utilization control and claims administration, and must provide most Medi-Cal covered health care services. In contrast to PHPs and PCCMs, COHSs are health insuring organizations which manage and pay for services on a capitated, at-risk basis, but do not directly provide care. Virtually all Medi-Cal beneficiaries with legal residency in the county must belong to the COHS. (Medi-Cal beneficiaries who are in recently established aid categories may not be covered due to a lack of historical data upon which to establish capitation rates.) Beneficiaries are given a wide choice of managed care providers but do not have the option of obtaining Medi-Cal services under the traditional fee-for-service system except for a few excluded services, e.g., some COHS contracts exclude long term care. Like the GMC program, capitation rates for each plan are negotiated by the California Medical Assistance Commission; rates are kept confidential.

COHSs currently exist in Orange, San Mateo, Santa Barbara, Santa Cruz, and Solano counties. DHS is awaiting approval from the federal government of its request to add Napa County to the Solano COHS.

As stated above, three COHSs operated in the 1980's, in the counties of Monterey, Santa Barbara, and San Mateo. Monterey ceased operations in 1985. Enabling State legislation and federal HCFA waiver approvals permitted three additional counties to form County Organized Health Systems. The Solano Partnership Health Plan began operations in May 1994. In October 1995 the California Orange Prevention and Treatment Integrated Medical Assistance Plan (CalOPTIMA) started enrolling Medi-Cal beneficiaries in its plan. In January 1996 the Santa Cruz County Health Options began operations.

Two-Plan Model

A plan for a new type of Medi-Cal managed care program was developed by DHS and issued March 31, 1993 under the title Expanding Medi-Cal Managed Care. Under this program, two HMO plans operate in each of the selected counties. One is operated under the auspices of the county government or a community based entity, e.g., an independent health commission; the other is operated as a private HMO selected by DHS through competitive bid. The two plans are directly administered by DHS and have to comply with the same contract requirements. The publicly-sponsored plan is referred to as the local initiative (LI), and the private HMO as the commercial plan (CP). It was envisioned that the LI would provide a means for hospitals, clinics, and physicians who traditionally cared for Medi-Cal beneficiaries under FFS, as well as the safety net providers who provide care to both Medi-Cal beneficiaries and other medically indigent persons, to continue providing these services under managed care. In the case of hospitals, this arrangement helps support

receipt of federal disproportionate share hospital funds. Contracts also help ensure that necessary cultural and linguistic services are available to those needing them. Both the LI and CP provide full medical services, including inpatient, and must be Knox-Keene licensed. Contract rates are established by DHS.

The mandatory aid category groups are: Aid to Families with Dependent Children (AFDC), Medically Needy with no share of cost , and Medically Indigent children. (Refer to Appendix, Table A.1 for a complete list of aid categories and their classification.) Those allowed to join voluntarily include those who are in an SSI or foster child aid category or who meet certain medical exemption criteria. In addition, eligibles in a mandatory aid category will not be in a plan during the months they are retroactively eligible for Medi-Cal, or for the first two months of their eligibility, during which time they are going through the selection/assignment process.

The counties selected by DHS for the Two-Plan Model were initially Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. Subsequently, San Diego was legislatively chosen to implement the GMC program (see above), and Fresno chose not to implement a local initiative, thereby resulting in DHS selecting a second commercial plan for that county.

Special Projects

DHS is continuously developing new types of managed care programs to provide better, more coordinated systems of care for Medi-Cal beneficiaries to result in their improved health status and to avoid non-duplicative or otherwise unnecessary costs. Two types of such special projects are:

Medical Case Management of High Cost Beneficiaries -- DHS has established programs to manage high-cost Medi-Cal beneficiaries within the fee-for-service (FFS) environment. Under this program, DHS develops and conducts pilot projects through capitated savings sharing agreements under which these populations receive medical case management. Examples of this population include those with AIDS, severely disabled individuals, complex mental health needs, and persons with significant brain and spinal cord injuries.

Fee-for-Service Managed Care -- To improve the coordination of care for those beneficiaries in FFS and to encourage better continuity of care, DHS established fee-for-service managed care programs -- or gatekeeper model -- in Sonoma and Placer Counties, starting March and October 1997, respectively. (San Luis Obispo is in the planning stages.) Under this program, DHS enrolls beneficiaries with primary care providers for medical case management, thereby improving coordination of care and lowering costs.

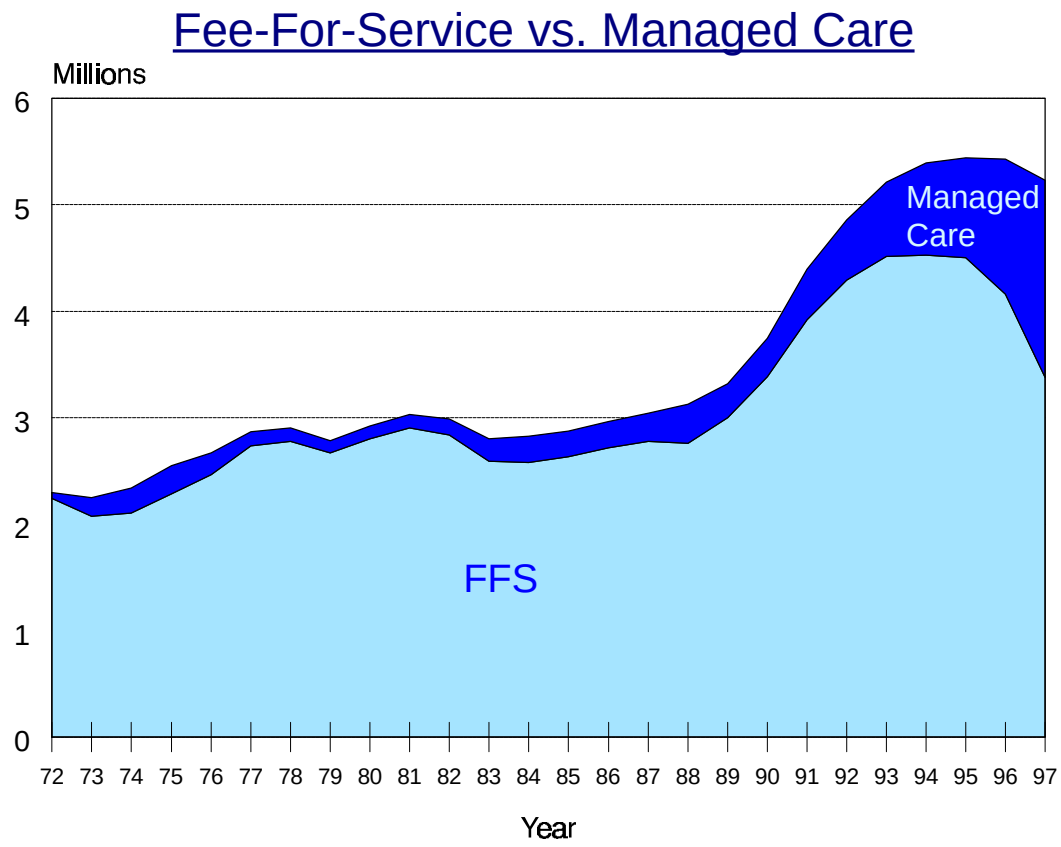
Scope of Services Covered by Managed Care

The scope of services covered by Medi-Cal plans is determined by their contract with DHS. Comprehensive plans typically cover inpatient care, limited skilled nursing services, and most outpatient services. Exceptions may vary from plan to plan and managed care model to managed care model. Plans are required, for services they must cover, to provide all medically necessary care, but may restrict such coverage to no more than the Medi-Cal Program would cover or may expand the coverage provided.

Tables 1.1A, Medi-Cal Eligibles by Program - Fee-For-Service vs. Managed Care

The following graph shows the annual enrollment in Medi-Cal for medical fee-for-service and managed care, from 1972 forward.

(Note: Two different methodologies were used for these counts. For 1972 through 1987, eligible counts are the average of the twelve calendar months, as reported in the Annual Statistical Report, published by the Medical Care Statistics Section, DHS. Because PCCM eligibles are not reported in the Annual and to provide more current data, from CY88 forward, eligible counts are for the month of July. Note that PCCM eligibles are included under managed care in this table.)



Tables 1.1B, Medi-Cal Eligibles by Program -Managed Care Programs

FFS-covered eligibles are excluded from this graph and the types of managed care programs are shown separately.

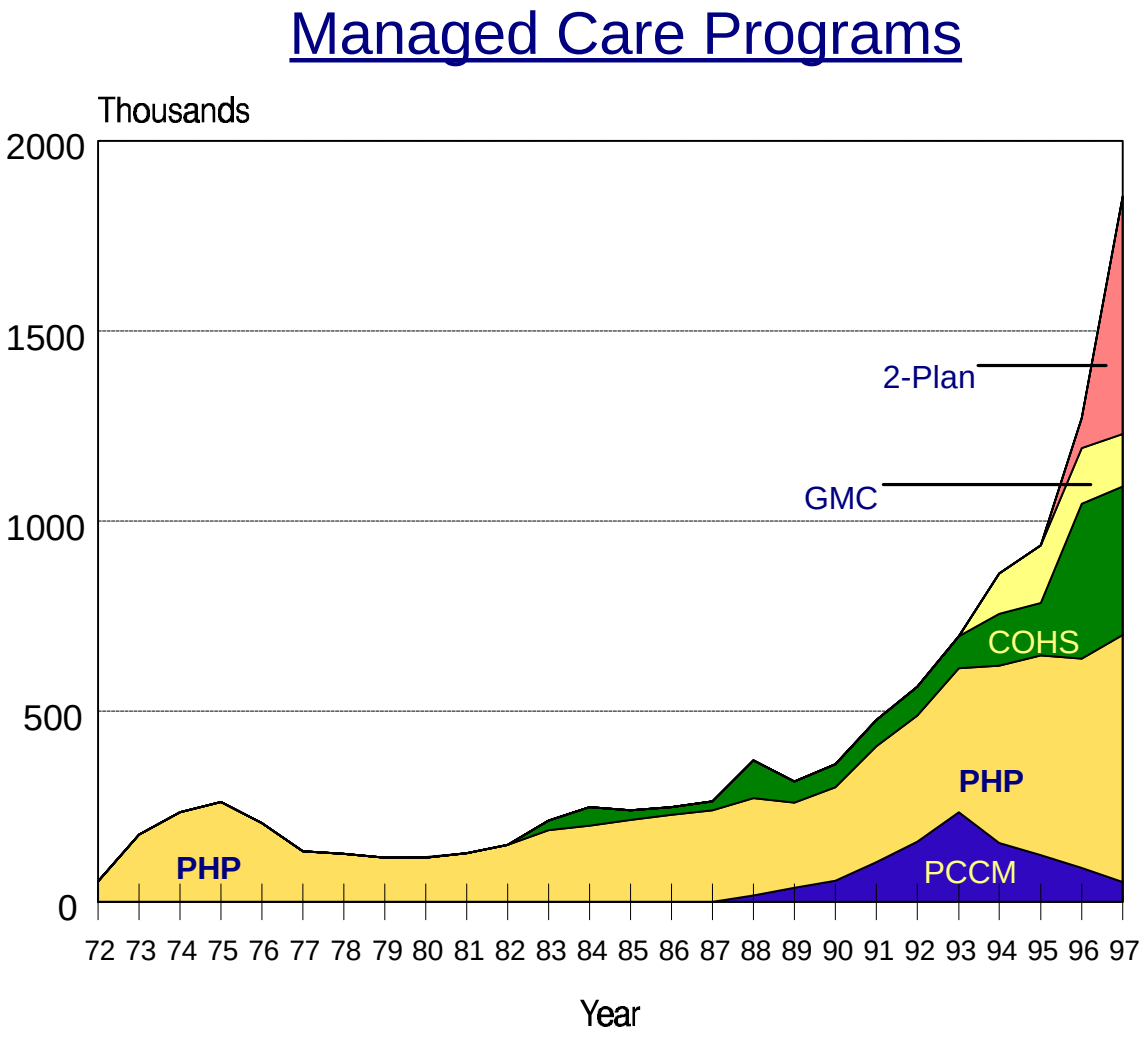


Table 1.2, Map of California's Managed Care Counties

The following map of California shows each county with either a managed care plan in operation or one scheduled to be implemented. (Note: Excludes PHP and PCCM programs.)

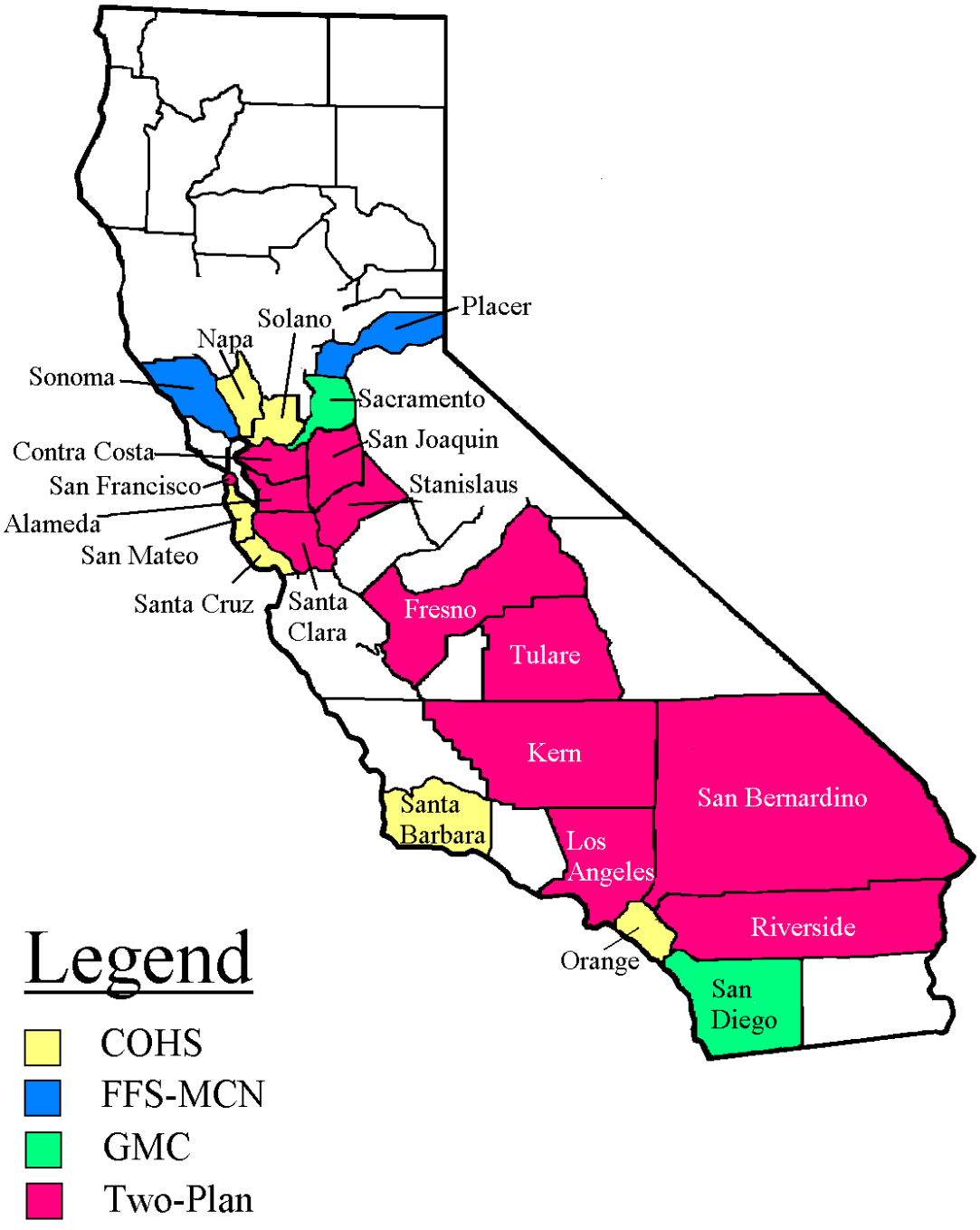


Table 1.3, Major Managed Care Plans, by County

The following table shows which Medi-Cal managed care plans are planned or are now operational by California county. The managed care programs covered are: County Organized Health Systems (COHS), Fee-For-Service Managed Care Network (FFS-MCN), Geographic Managed Care (GMC), andTwo-Plan. Excluded are Prepaid Health Plan (PHP), Primary Care Case Management (PCCM), and special projects (e.g., AIDS, SCAN).

County	Program	LI/ CP	Plan Name	Start Date	Enrollment Jul 97
Alameda	2-PLAN	LI	Alameda Alliance for Health	1/96	74,052
		CP	Blue Cross of California	7/96	25,765
Contra Costa	2-PLAN	LI	Contra Costa Health Plan	2/97	43,416
		CP	Foundation Health Plan	3/97	3,406
Fresno	2-PLAN	CP	Foundation Health Plan	1/97	17,921
		CP	Blue Cross of California	11/96	107,167
Kern	2-PLAN	LI	Kern Health Systems	7/96	54,461
		CP	Blue Cross of California	9/96	23,701
Los	2-PLAN	LI	LA Care Health Plan	4/97	192,661
Angeles		CP	Foundation Health Plan	7/97	256,812
Orange	COHS		CalOptima	10/95	224,244
Placer	FFS/MCN		Placer County Health Plan	10/97	na
Riverside	2-PLAN	LI	Inland Empire Health Plan	9/96	64,201
		CP	Molina Medical Centers	2/98	na
Sacramento	GMC		various private HMOs	4/94	139,101
San	2-PLAN	LI	Inland Empire Health Plan	9/96	69,230
Bernardino		CP	Molina Medical Centers	2/98	na
San Diego	GMC		various private HMOs		na
San	2-PLAN	LI	San Francisco Health Authority	1/97	23,255
Francisco		CP	Blue Cross of California	7/96	15,761
San	2-PLAN	LI	Health Plan of San Joaquin	2/96	60,404
Joaquin		CP	Omni HealthCare	2/97	11,567
San Mateo	COHS		Health Plan of San Mateo	12/87	45,388
Santa Barbara	COHS		Santa Barbara Health Initiative	9/83	38,996
Santa	2-PLAN	LI	Santa Clara Health Authority	2/97	43,682
Clara		CP	Blue Cross of California	10/96	34,876
Santa Cruz	COHS		Santa Cruz County Health Plan	1/96	23,081
Solano	COHS		Solano Partnership Health Plan	5/94	44,768
Sonoma	FFS/MCN		Sonoma County Partners for Health Managed Care Network	3/97	13,333
Stanislaus	2-PLAN	LI	Stanislaus Co. Local Hlth. Initiative	10/97	na
		CP	Omni Health Care	2/97	9,223
Tulare	2-PLAN	LI	MediCo		na
		CP	Foundation Health Plan		na

* Start Date was the first day of the month for all plans.

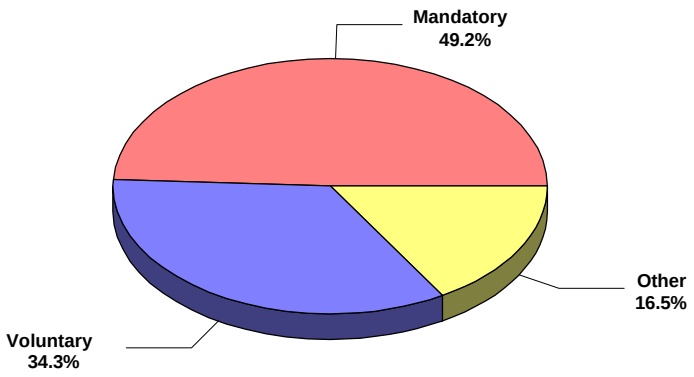
** Source for number of eligibles for all plans except the COHS and FFS/MCN is the Enrollment Summary Report produced by the Medi-Cal Managed Care Division. COHS and FFS/MCN data are form the Monthly Medi-Cal Eligibility File.

Table 1.4, PIE Charts of Aid Category Groups by FFS and Managed Care

As Table 1.3, "Major Managed Care Plans by County" illustrates, all GMC and Two-Plan Model county managed care plans have not been fully implemented as of July 1997. The following pie charts show the extent of this implementation. The first pie chart demonstrates that, of those eligibles remaining in fee-for-service in the COHS, GMC, and Two-Plan Model counties, almost half (49%) are in aid categories considered mandatory for the Two-Plan Model (primarily AFDC). Of the managed care eligibles in these counties, about 10% are in in aid categories considered voluntary under the Two-Plan Model. (See Appendix, Table A.1 for definitions of these groupings.) Upon full implementation in these (COHS, GMC, and Two-Plan) counties, over 80% of this mandatory group will be enrolled in a managed care plan.

Source of these data is the July 1997 month of eligibility Medi-Cal Eligibles File using a four month lag.

Fee-For-Service Eligibles



Managed Care Eligibles

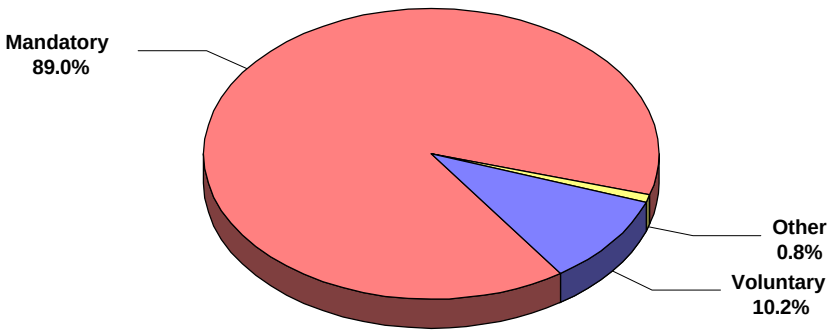


Table 1.5, Percent of Eligibles in FFS and Managed Care, by County

The following chart shows the percent of the Medi-Cal eligible population enrolled in managed care or in fee-for-service. (Note: Tulare is not shown due to lack of a managed care plan in that county.)

Source of these data is the July 1997 month of eligibility Medi-Cal Eligibles File using a four month lag.

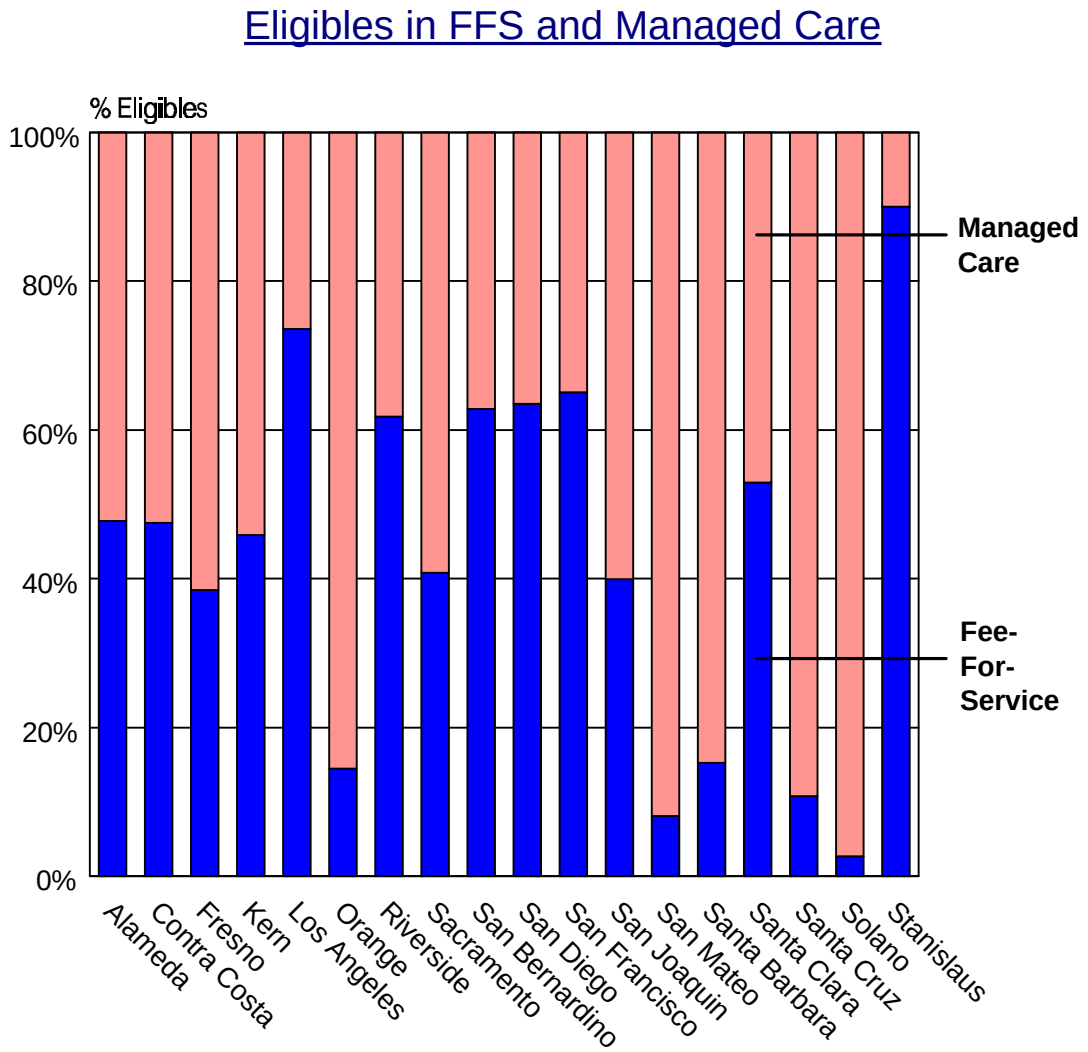


Table 1.6, Percent Mandatory Eligibles in Managed Care of All Mandatory Eligibles, Two-Plan Model Counties Only

The following chart shows the percent of the Medi-Cal eligible population enrolled in managed care or in fee-for-service, but for only the Medi-Cal population that would be required to join a managed care (i.e., the Two-Plan Model mandatory aid categories). (Note: Tulare is not shown due to lack of a managed care plan in that county.) The month of eligibility for these data is July 1997 month of eligibility using a four month lag. (Note: Not all counties were fully implemented as of July 1997. See Table 1.3 for implementation dates by county.)

The percent of those in a mandatory aid category is always less than 100%. This is because, even though a beneficiary is in a mandatory aid category, they will not necessarily end up in a managed care plan. Reasons for this include: 1) managed care implementation is still in process; 2) the beneficiary received Medi-Cal eligibility retroactively (that is, between the start of the eligibility month and up to four months later); 3) the beneficiary has some kind of other coverage (usually, CHAMPUS, Medicare HMO, Kaiser, or some PHP/HMO and EPO coverage) that excludes them from enrolling in a plan; 4) the beneficiary just became eligible for Medi-Cal in a particular county, and is still in the process of selecting a plan or will be defaulted into one; 5) the beneficiary lives in an exempted zip code; 6) in certain counties, the beneficiary is also enrolled in the California Children Services (CCS) program; and, 7) the beneficiary has a medical exemption from belonging to a managed care, as granted by the DHS. For a complete list of these exemptions, contact the DHS Medi-Cal Managed Care Division.

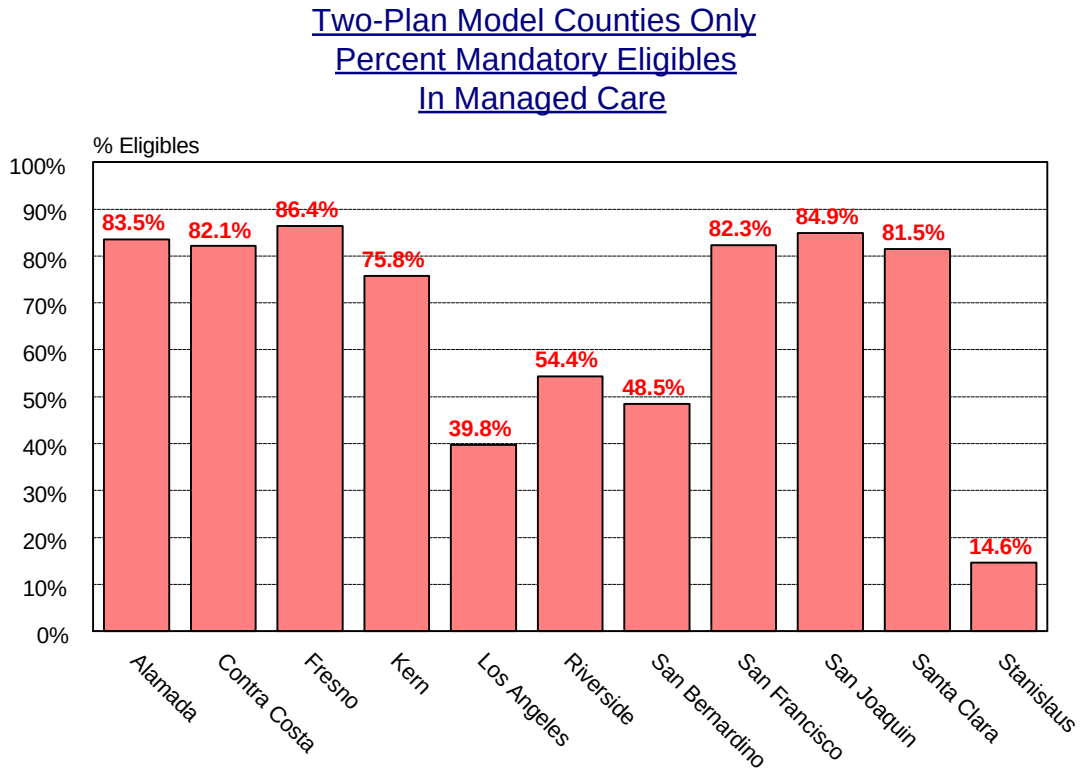
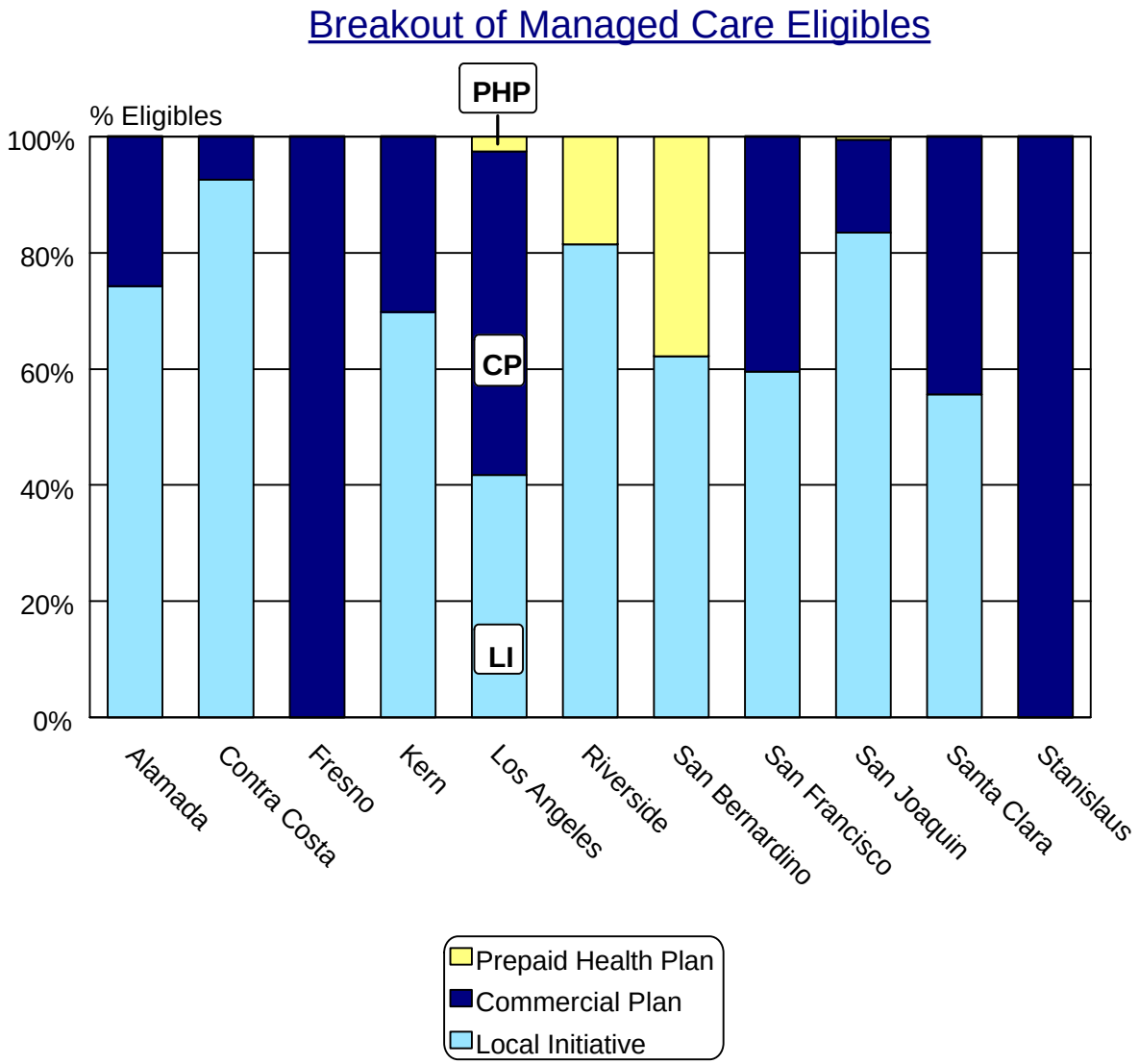


Table 1.7, Breakout of Managed Care Eligibles by Program and County, Two-Plan Model Counties Only

The following chart shows the percent of the Medi-Cal eligible population enrolled in managed care by managed care program, effective with the July 1997 month of eligibility, using a four month lag. (Note: Placer and Tulare are not shown due to lack of any managed care plans in those counties in July 1997. In addition, since the five COHS counties only have the one program of managed care, these counties are also not shown here.)



Section 2, Demographic Characteristics

The beneficiaries in the aid categories considered mandatory under the Two-Plan Model have a different demographic profile than the non-mandatory beneficiaries. This former group, which includes the AFDC and AFDC-linked aid categories, would, under most circumstances, have to join a managed care plan within a COHS, GMC, or Two-Plan Model county. The following tables contrast the demographic characteristics of the AFDC population with those of the "voluntary" and "other" groups for all Medi-Cal eligibles (managed care and fee-for-service). (See Appendix, Table A.1 for definitions of Two-Plan Model mandatory, voluntary, and "other" categories.)

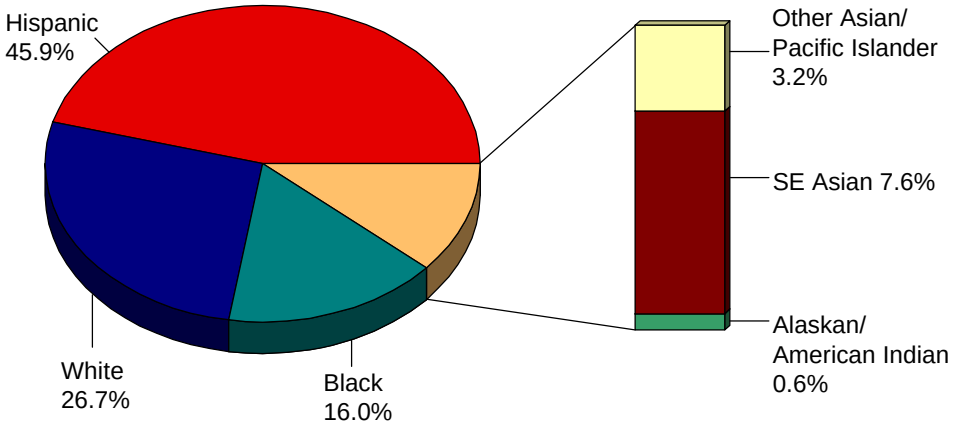
(Note: Since the non-mandatory population for the Two-Plan Model counties-- which includes predominately the SSI population -- has a relatively high percent of blank values for ethnicity and language, such records were ignored in determining the percentages shown on the following two pages. This was done assuming this population has a composition similar to those with valid values.)

Table 2.1, Breakout of Eligibles by Major Ethnic Groups

The following charts show a distribution of the Medi-Cal eligible population in managed care (COHS, GMC, Two-Plan) counties by major ethnic category. The first chart shows this breakout for the population considered Mandatory under the Two-Plan model, that is, primarily AFDC-Cash Grant. The second chart covers those not in a Mandatory aid category group.

Source of these data is the July 1997 month of eligibility Medi-Cal Eligibles File using a four month lag.

Mandatory Eligibles



Non-Mandatory Eligibles

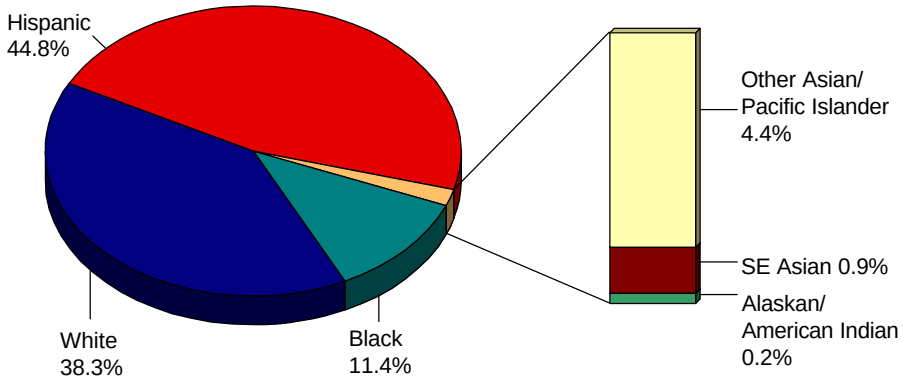
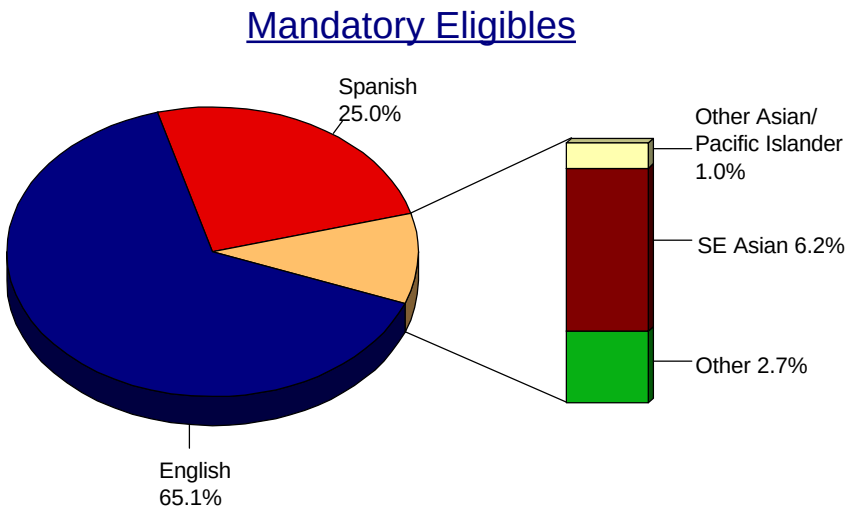


Table 2.2, Breakout of Eligibles by Major Language Category

The following charts show a distribution of the Medi-Cal eligible population in managed care (COHS, GMC, Two-Plan) counties by major language category. The first chart shows this breakout for the population considered Mandatory under the Two-Plan model, that is, primarily AFDC-Cash Grant. The second chart covers those not in a Mandatory aid category group.

Source of these data is the July 1997 month of eligibility Medi-Cal Eligibles File using a four month lag.



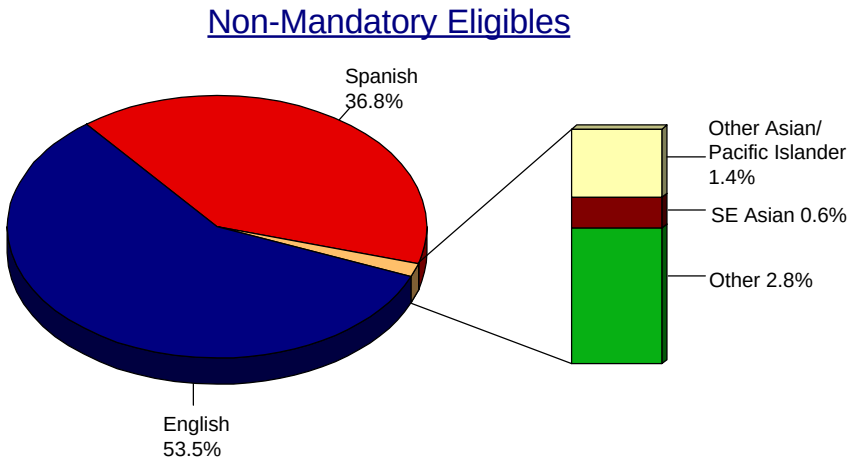


Table 2.3, Breakout of Eligibles by Age, Gender, and Aid Category Groups

Those in managed care are predominately those on AFDC and, as such, have certain age and gender characteristics distinguishing them as a group from those in the groups designated as voluntary and "other" within the Two-Plan Model counties. (See Section 1 of this report for an explanation of "mandatory", "voluntary", and "other.")

Note: The area shown for each gender represents the total number of eligibles. For example, in the chart below for the mandatory aid category population, the total number of female eligibles "4 and under" is 400,000, whereas the number of males "4 and under" is 420,000. The **total** number of eligibles (top edge of the area represented by the Male variable) for "4 and under" is thus 820,000. By the same token, the number of females in the "20-24 yrs" category is 153,500, the number of males in this category is 27,400, and the total is 180,900.

(See Appendix, Table A.1 for definitions of Two-Plan Model mandatory, voluntary, and "other" categories.)

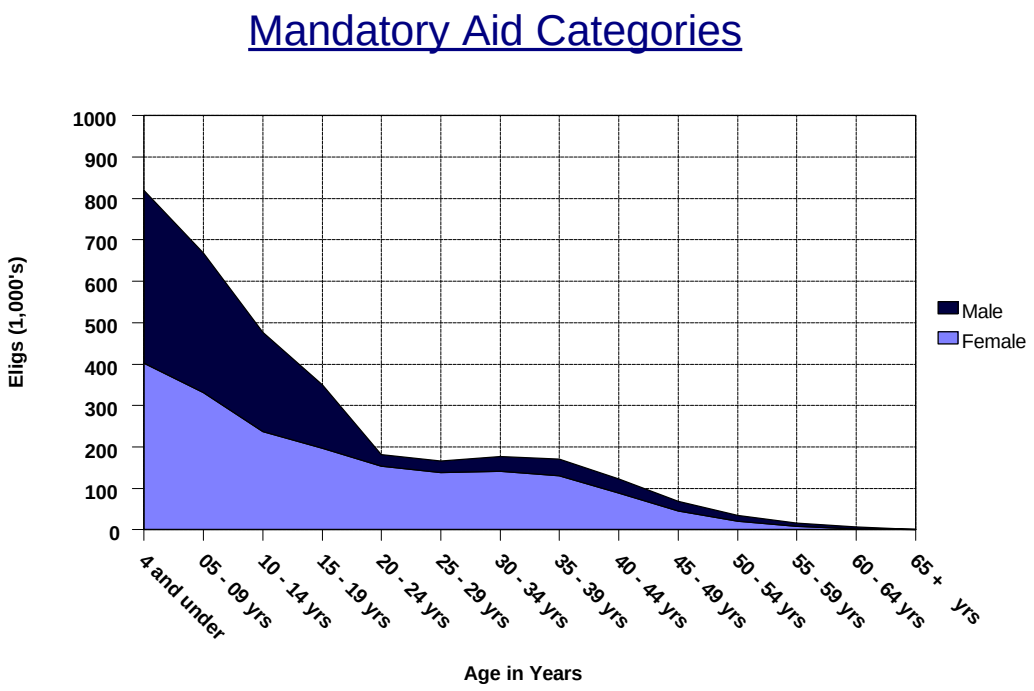
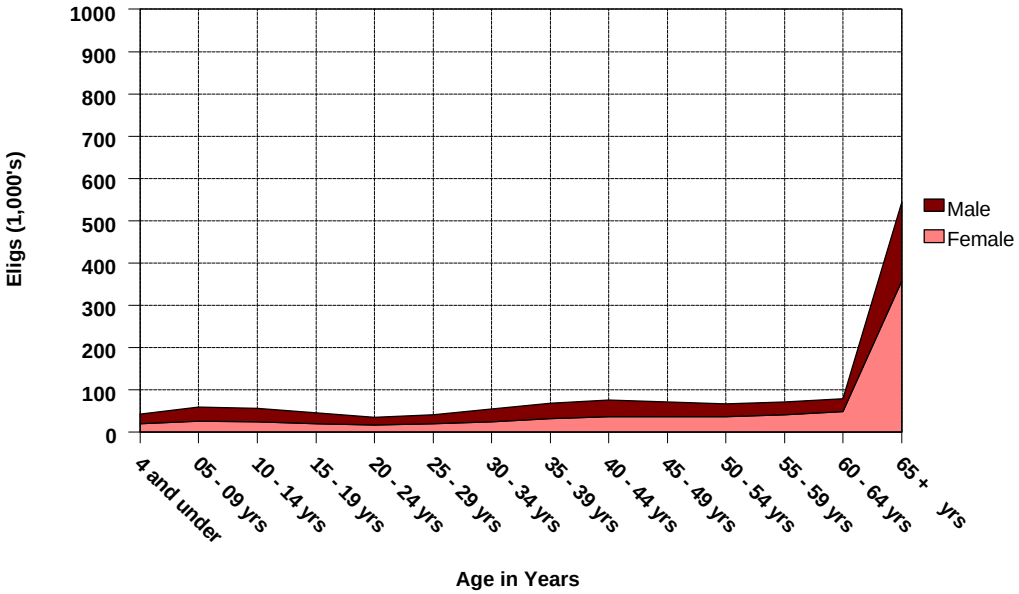
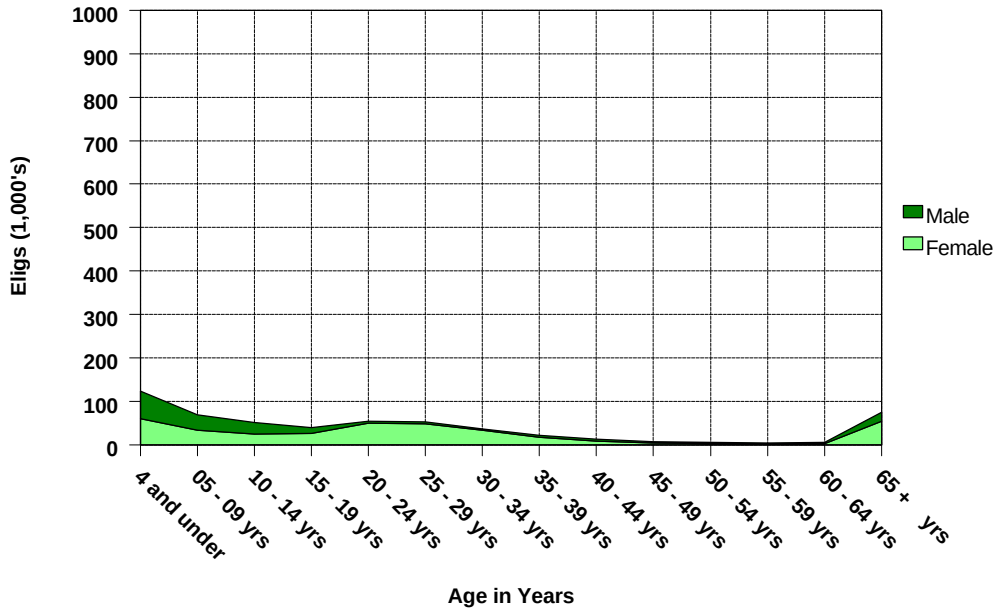


Table 2.3, Breakout of Eligibles by Age, Gender, and Aid Category Groups (continued)

Voluntary Aid Categories



Other Aid Categories



Section 3, Eligibility Continuity and Rate of New Eligibles

The length of time someone is on Medi-Cal is an important factor in the provision of medical services under managed care. The longer and more continuously a person is enrolled in a managed care plan, the easier it should be for a beneficiary to receive preventive and continuous care. Other benefits include the development of a closer relationship between the primary care physician and the beneficiary, and less administrative cost to the plan. One way to measure duration of eligibility is to determine how long individual beneficiaries are continuously Medi-Cal eligible. Tables 3.1 and 3.2 provide rates of continuous eligibility for a recent period of time, without regard to a person's pre-existing eligibility. Table 3.3 provides a continuous eligibility rate for those most likely to belong to a Medi-Cal managed care plan, the AFDC-Cash Grant beneficiaries, after at least one month of Medi-Cal ineligibility.

Another useful measure of the stability of the Medi-Cal population in terms of eligibility is the rate at which new eligibles get on Medi-Cal. One measure of this is to determine the number of eligibles moving from ineligibility to eligibility status, and to express this as a percent of all eligibles. This rate was derived for all eligibles as well as just the managed care mandatory aid category population, and is depicted in Table 3.4.

Note: The information used to construct these tables was derived from a longitudinal data base for a five percent sample of all Medi-Cal beneficiaries. The period represented is January 1994 through December 1996 (shown on the tables as Month 00 and Month 36, respectively).

Table 3.1, Continuity of Eligibility in Aggregate

The following chart shows how long a beneficiary would tend to remain eligible for Medi-Cal over a three year period. **Note that recent federal and State legislation as well as an improved economy will likely have a major impact on the rate at which persons stay eligible for Medi-Cal. This chart reflects eligibility trends only as they existed during the CY94 through CY96 period and thus may not be representative of future patterns.**

To establish the rates shown below, each beneficiary from our data base was tracked for thirty-six months, regardless of their eligibility status in the month preceding the period. Any break in eligibility would drop an eligible from the curve at that point. (Studies have shown only a slight difference in the percent continuously eligible when a one month break is allowed in the definition.)

The curve labeled "Aggregate" shows the rate at which a person who was eligible for Medi-Cal in the first month is likely to remain on Medi-Cal each month for up to thirty-six months. The chart shows that 75% of this population will likely still be on Medi-Cal after the first year, 59% after two years, and 50% after three. If this population were subsumed into eight relatively homogenous (in terms of eligibility) groups, the rate of continuous eligibility for all these beneficiaries staying within their assigned group is shown in the chart as "Aggregate - All Groups." (The difference between the curves is the population who were continuously eligible, but went from one eligibility group to another.)

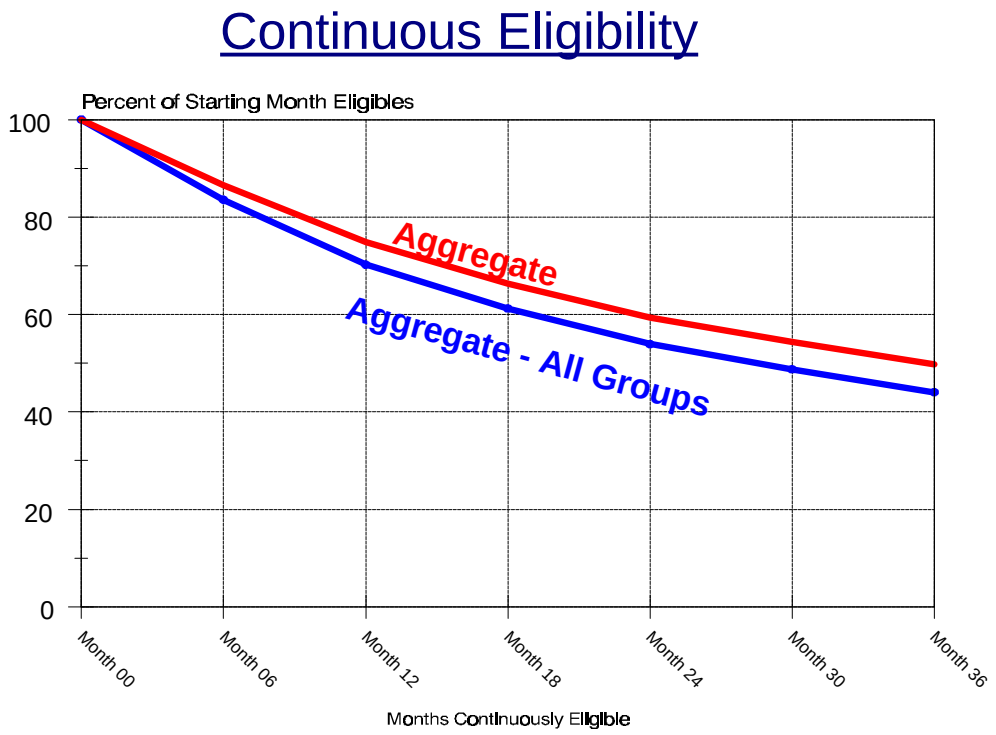


Table 3.2, Continuity of Eligibility by Major Aid Category Group

The following chart is similar to Table 3.1, except that eligibles were subsumed into distinct eligibility groups. Each curve represents those eligibles who belong to an assigned group for the months shown. If a Medi-Cal eligible either ceases being eligible, or "jumps" to one of the other seven groups, they are excluded from the curve at that point.

The eight major groups shown in the chart are: 1. SSI/SSP; 2. Long Term Care; 3. AFDC - Cash Grant; 4. Medi-Cal only, Families; 5. Medi-Cal only, Aged, Blind, Disabled, no share of cost; 6. Share of cost; 7. OBRA; 8. Miscellaneous. (For a listing of the aid categories making up each of these groupings, refer to the Appendix, Table A.2.)

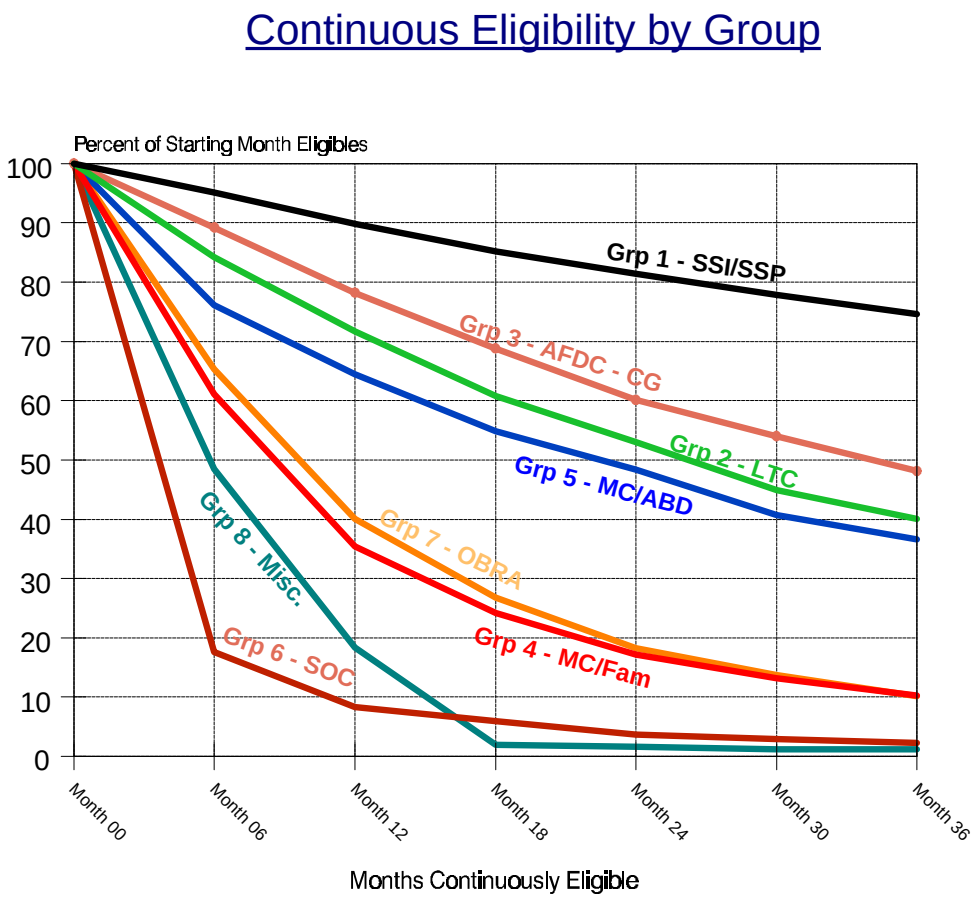


Table 3.3, Continuity of Eligibility for AFDC - Cash Grant -- New Eligibles

Tables 3.1 and 3.2 show continuous eligibility rates for Medi-Cal eligibles for a three year period without regard to their prior eligibility status. It may also be of interest to know the rate of continuous eligibility for those who were ineligible for at least one month immediately prior to the three year study period. The following chart shows two rates of continuous eligibility for AFDC - Cash Grant eligibles (those most likely to go into managed care): 1) "ALL" -- the continuous eligibility rate for AFDC - CG (see Table 3.2); 2) "NEW" -- the rate of eligibility for the subset population who was not on Medi-Cal during the month before Month 00.

As indicated, the attrition **rate** for the NEW eligibles group declines quicker than for the ALL eligibles group, especially for months 06 through 12. One explanation for this may be that many persons who first become eligible for Medi-Cal only stay on Medi-Cal for a short period. As the duration of the Medi-Cal eligibility period increases, however, the attrition rate more closely resembles the one for those on Medi-Cal for longer periods.

Note that the ALL eligibles percent is higher than that for the NEW eligibles for each month. This is due to the fact that the undepicted "tail" of the right-skewed NEW eligibles curve builds up the curve to produce the ALL eligibles curve. That is, not only does the ALL eligibles curve include new eligibles, but also those on Medi-Cal for two, three, etc. years at Month 00.

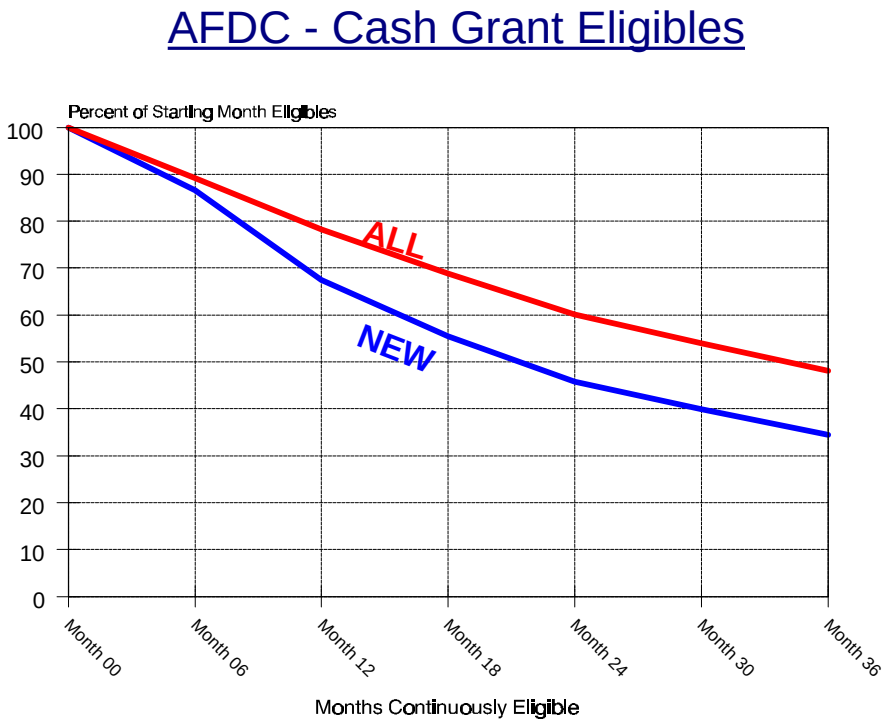
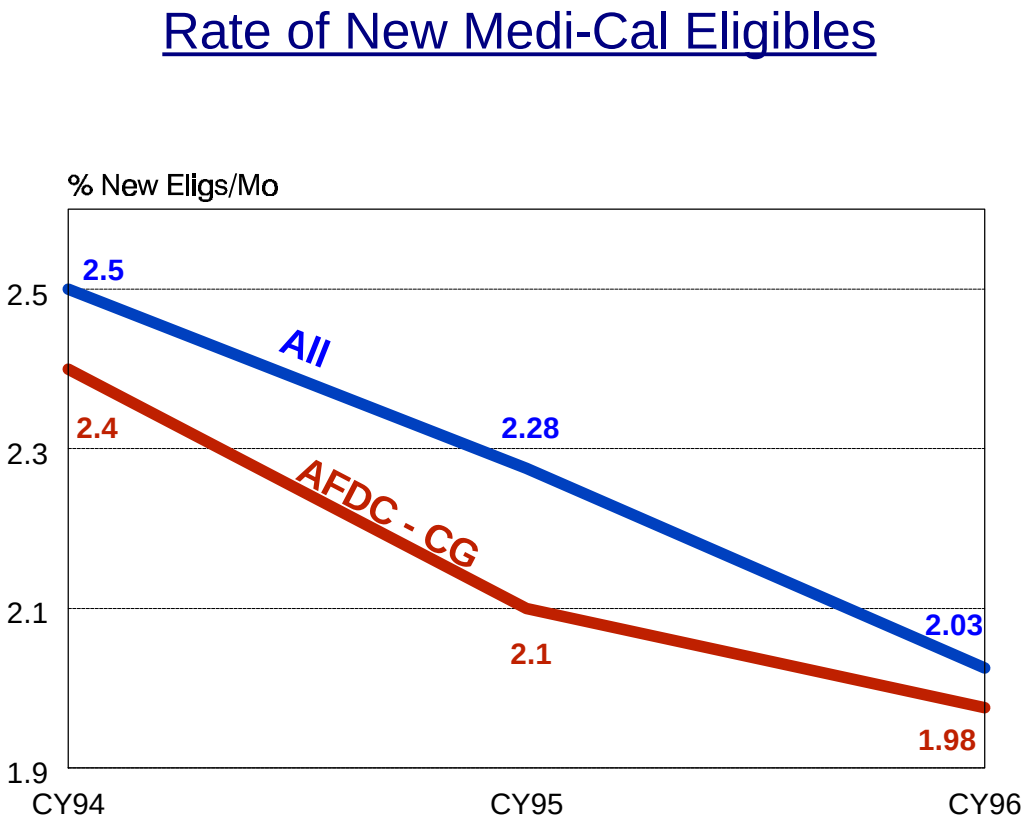


Table 3.4, Rate of New Beneficiaries on Medi-Cal

As with continuity of eligibility, the rate at which beneficiaries become eligible for Medi-Cal provides some measure of the turnover of this population. As mentioned above, this in turn can have a direct impact on the quality of care provided under managed care. The following chart shows the rate at which beneficiaries become eligible for Medi-Cal after being ineligible (not on Medi-Cal) for six months.

The percentages shown in this chart were derived by first calculating a denominator of a count of eligibles for the months February, May, August, and November for the calendar years 1994 through 1996. A subset of this population, those ineligible the previous six months, was used to calculate a percent or rate of those "new" to Medi-Cal each month. The same methodology was used to develop a rate for the eligibles most likely to be in a managed care plan in Two-Plan Model and GMC counties. (See Appendix, Table A.1 for a list of these mandatory aid categories.)

As information from this chart suggests, the overall rate of persons becoming eligible for Medi-Cal is dropping. The chart also indicates that the rate at which the mandatory aid category eligibles (primarily AFDC - CG) are becoming eligible is less than the overall rate, although this disparity substantially decreased in CY96.



Appendices

Appendix, Table A.1, List of Aid Categories by Managed Care Model and Type of Membership Status

The following table provides a list by aid categories, and which are considered mandatory (M), vs. voluntary (V), vs. Blank (can't join) for each plan model.

Managed Care Aid Categories by Plan Model

	COHS				GMC	FFS/MCN	Two-Plan	PHP / PCCM
Aid Cat.	Napa	Orange	San Mateo & Solano	Santa Barbara & Santa Cruz	Sacramento	Placer & Sonoma		
01	M	M	M	M	V	V	M	V
02	M	M	M	M	V	V	M	V
03	M	M	M	M	V	V	V	V
04	M	M	M	M	V	V	V	V
08	M	M	M	M	V	V	M	V
0A	M	M	M	M	V	V	M	V
10	M	M	M	M	V	V	V	V
13	M	M	M	M				
14	M	M	M	M	V	V	V	V
16	M	M	M	M	V	V	V	V
17	M	M	M	M				
18	M	M	M	M	V	V	V	V
20	M	M	M	M	V	V	V	V
23	M	M	M	M				
24	M	M	M	M	V	V	V	V
26	M	M	M	M	V	V	V	V
27	M	M	M	M				
28	M	M	M	M	V	V	V	V
30	M	M	M	M	M	M	M	V
32	M	M	M	M	M	M	M	V
33	M	M	M	M	M	M	M	V
34	M	M	M	M	M	M	M	V
35	M	M	M	M	M	M	M	V
36		M	M	M	V	V	V	V
37	M	M	M	M				
38	M	M	M	M	M	M	M	V
39	M	M	M	M	M	M	M	V
3A	M	M	M	M	M	M	M	V
3C	M	M	M	M	M	M	M	V
3G	M	M	M	M	M	M	M	V
3H	M	M	M	M	M	M	M	V
3P	M	M	M	M	M	M	M	V
3R	M	M	M	M	M	M	M	V
40	M	M	M	M	V	V	V	V
42	M	M	M	M	V	V	V	V
45	M	M	M	M	M	V	M	V
4C	M	M	M	M	V	V	V	V
4K	M	M	M	M	V	V	V	V

Appendix, Table A.1, List of Aid Categories by Managed Care Model and Type of Membership Status (continued)

Managed Care Aid Categories by Plan Model (continued)

		COHS			GMC	FFS/MCN	Two-Plan	PHP / PCCM
Aid Cat.	Napa	Orange	San Mateo & Solano	Santa Barbara & Santa Cruz	Sacramento	Placer & Sonoma		
53	M		M	M				
54	M	M	M	M	M	M	M	V
55	M		M					
58	M		M					
59	M	M	M	M	M	M	M	V
5F	M		M					V
5G	M		M					
5K	M	M	M	M	V	V	V	V
5N	M		M					
60	M	M	M	M	V	V	V	V
63	M	M	M	M				
64	M	M	M	M	V	V	V	V
65	M	M	M	M				
66	M	M	M	M	V	V	V	V
67	M	M	M	M				
68	M	M	M	M	V	V	V	V
6A	M	M	M	M	V	V	V	V
6C	M	M	M	M	V	V	V	V
81	M	M	M	M				
82	M	M	M	M	M	M	M	V
83	M	M	M	M				
86	M	M	M	M	V	V	V	V
87	M	M	M	M				

Appendix, Table A.2, List of Aid Categories Used For Continuous Eligibility Charts in Section 3

Major Grouping		Minor Grouping	Aid Categories
Elig Study	CIDCUM		
1. SSI/SSP	CASH GRANT	AB	20, 22
1. SSI/SSP	CASH GRANT	ATD	60, 62
1. SSI/SSP	CASH GRANT	OAS	10, 12
1. SSI/SSP	IN HOME SUPPORT	AB	28
1. SSI/SSP	IN HOME SUPPORT	ATD	68
1. SSI/SSP	IN HOME SUPPORT	OAS	18
2. LTC	MI ADULT	------	53
2. LTC	MN-LONG TERM NG	AB	23
2. LTC	MN-LONG TERM NG	ATD	63
2. LTC	MN-LONG TERM NG	OAS	13
3. AFDC-CG	CASH GRANT	AFDC	06, 30, 32, 33, 35, 38, 40, 42, 43
3. AFDC-CG	CASH GRANT	AFDC	77, 78, 3A, 3C, 3P, 3R, 3G, 3H
4. M/C only, Families, No SOC	TRANSITIONAL	AFDC	39, 54, 59
4. M/C only, Families, No SOC	CHILDREN	------	72, 74, 7A, 7C
4. M/C only, Families, No SOC	INFANTS	------	07, 47, 69, 79
4. M/C only, Families, No SOC	MI ADULT	------	86
4. M/C only, Families, No SOC	MI YOUTH	------	45
4. M/C only, Families, No SOC	MI YOUTH	------	4K
4. M/C only, Families, No SOC	MI YOUTH	------	04
4. M/C only, Families, No SOC	MI YOUTH	------	5K
4. M/C only, Families, No SOC	MI YOUTH	------	03
4. M/C only, Families, No SOC	MI YOUTH	------	82
4. M/C only, Families, No SOC	MINOR CONSENT	------	7M, 7P, 7R
4. M/C only, Families, No SOC	MN - NO SOC	AFDC	34
4. M/C only, Families, No SOC	WOMEN	------	44, 48, 49, 70, 75, 76, 7F, 7G
5. M/C only, ABD, No SOC	MN - NO SOC	AB	24
5. M/C only, ABD, No SOC	MN - NO SOC	ATD	64
5. M/C only, ABD, No SOC	MN - NO SOC	OAS	14
5. M/C only, ABD, No SOC	TITLE II DISRGRD	AB	25, 26, 6A
5. M/C only, ABD, No SOC	TITLE II DISRGRD	AFDC	46
5. M/C only, ABD, No SOC	TITLE II DISRGRD	ATD	36, 66, 6C
5. M/C only, ABD, No SOC	TITLE II DISRGRD	OAS	15, 16
6. SOC	MI ADULT	------	87
6. SOC	MI YOUTH	------	83
6. SOC	MN - SHR OF COST	AB	27
6. SOC	MN - SHR OF COST	AFDC	37
6. SOC	MN - SHR OF COST	ATD	65, 67
6. SOC	MN - SHR OF COST	OAS	17
7. OBRA	OBRA ALIENS	------	55, 58, 5F
8. Miscellaneous	ICRA ALIENS	------	51, 52, 56, 57
8. Miscellaneous	MI ADULT	------	81
8. Miscellaneous	PARENTERAL NUTRI	------	73
8. Miscellaneous	QMB-ONLY	------	80
8. Miscellaneous	REFUGEES	------	01, 0A, 02, 08
8. Miscellaneous	RENAL DIALYSIS	------	71
8. Miscellaneous	TB PROGRAM	------	7H